ChiroCenter
Bloomington

8120 Penn Avenue South, Suite 525
Bloomington, MN 55431

ASSIGNMENT OF INSURANCE PROCEEDS

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing, massage therapy, or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to ChiroCenter Bloomington any insurance proceeds including accident, health and worker's compensation insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I am responsible for all charges to my account.

Initials_____

RECORDS RELEASE AUTHORIZATION

To: ChiroCenter Bloomington

You are authorized to release any information contained in my file to any insurance company, attorney, adjustor, or member of your office staff, including any contracted billing services representing ChiroCenter Bloomington, or its associates, in order to process any claim for reimbursement for charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

Initials_____

COSTS OF COLLECTIONS (Collection Agency or Attorney)

I understand that if I fail to pay my account as agreed, ChiroCenter Bloomington may, after reasonable attempts to obtain payment, place my account for collection. I understand that if my account is placed for collection with an agency, payments made after collection agency placement result in an agency service fee of 1/3 of any paid amount. If my account is placed for collection, I agree to pay such costs of collection up to 1/3 of the amount covered.

Initials_____

I have read and agreed with the clinic's policy regarding Assignment of Insurance, Release of Records, and Costs of Collections.

Signature_________________________________

Date_____________________________________